Mississauga Halton **LHIN**

Partnering for a healthier tomorrow

Integrated Health Service Plan 2013 – 2016

Ontario
Local Health Integration Network

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1.0

Executive Summary

"In our current changing environment we need to be flexible and able to address challenges in new, innovative ways. We need to be evidence-informed, connected to our community and confident to respond in the appropriate manner."

The 2013-2016 Mississauga Halton Integrated Health Service Plan (IHSP) is the third strategic plan developed by the Mississauga Halton Local Health Integration Network (LHIN)[i]. The IHSP essentially is a shared road map. It will help all of us understand our local health care priorities and the steps we must take together to build the health care system that meets our needs now and in the future.

This new IHSP, in alignment with the province's Action Plan for Health Care and provincial LHIN system imperatives, has been developed based on an environmental scan of our region (including demographic information and health care utilization), a review of the successes and lessons learned over the past six years, a comprehensive literature review and the voices of people from our communities that we engaged with – consumers, caregivers, health service providers, cross-sector partners and the community at large.

Five key priority areas have been identified within this IHSP, with specific goals under each priority:

Accessible and Sustainable Health Care

- Improve access to services to improve consumer flow, quality and safety
- Support consumers, families and health care professionals to navigate the health care system
- Improve sustainability of the health care system

Enhanced Community Capacity

- Enable people to stay in their homes longer
- Provide integrated services that bring care closer to home

Family Health Care When You Need It

- Improve access to family health care[ii]
- Increase linkages between family health care and other health care providers to improve communication, coordination and integration across the continuum of care

Optimal Health – Mental and Physical

- Increase healthy habits and prevention of disease
- Build partnerships for healthy communities

High Quality Person-Centred Care

- Support and foster a quality culture across the continuum of care
- Value people's experiences to support system improvement
- Apply a health equity lens for the delivery of health care services

Strategies have been identified to move us forward on each of the goals, along with key measures of success to keep us focused on our desired outcomes. The five priorities identified are not mutually exclusive. However, we have tried to articulate priorities that are meaningful and resonate with everyone in the LHIN, so that we can work in collaboration to achieve our local vision of a seamless health system for our communities – promoting optimal health and delivering high quality care when and where needed.

Essential to the success of the IHSP are a number of key enablers:

- Building Awareness
- Health System Funding Reform
- Community Engagement
- Information Management & Technological Advances
- Collaborative Governance
- Communication
- Accountability Management
- Partnerships

Over the next three years, we will leverage these enablers to support achievement of the goals identified under each of the five priorities. We will further articulate or "action" our strategies every year in our Annual Business Plan. The measures of success will be reviewed regularly to guide and refine our plans over the next three years and keep us on the right path.

Is our plan ambitious? Yes. But more importantly, it is realizable. In our current changing environment we need to be flexible and able to address challenges in new, innovative ways. We need to be evidence-informed, connected to our community and confident to respond in the appropriate manner.

The 2013-2016 Mississauga Halton LHIN IHSP was built in the spirit of partnership. By developing a plan that is not only evidence-based but built on the foundation of the voices of the people that it serves, everyone should have a vested interest and a stake in achievement of its success. The future is ours… so let's work together to build a healthier tomorrow!

2.0 Introduction

We all want to be healthy. Good health enables us to live our lives to the fullest, to be adventurous and to enjoy life! There comes a time in most people's lives however, where we may need some assistance to keep us or our significant others as healthy as possible. At this point, we will likely turn to the health care system to help us in our time of need. When we do, we trust that health care providers are able to work together to deliver the care we require and support us in the best manner possible.

It is the common goal of "good health for all" that makes us partners in the health care system. We all play different roles, but we are all working towards a shared vision of a healthy Ontario… healthier people, healthier communities and a healthier system for all.

A strategic plan is a road map that helps individuals and/or organizations move closer to achieving their goals or overarching vision. The Integrated Health Service Plan (IHSP) is a strategic plan established by the Mississauga Halton Local Health Integration Network (LHIN). As a regional health agency, the LHIN brings health care providers together to meet the specific health care needs of the people in Mississauga Halton. Developed in alignment with provincial health priorities and based on feedback received from the community as well as an environmental scan, the IHSP helps guide the priorities and activities of the LHIN and the health service providers it funds.

The 2013-2016 IHSP is the third strategic plan developed by the LHIN. Building on the successes and lessons learned from the previous two plans, this new plan is built with a clear focus on the person (patient/consumer, caregiver, family member) as a partner at the centre of all that we do. Focusing on quality is also a key element of this plan; we must all strive towards achieving and supporting quality care if we want to create a sustainable health care system. This includes applying a health equity lens to our work to ensure that people who are in the greatest need of health care receive it and barriers to getting care are eliminated.

The new IHSP has been built on the foundation of people's voices… we met with our communities, we connected with health service providers, we listened. This new plan speaks to the opportunities that people identified, the challenges that they currently face, the need to work with partners to build our future health system. At a high level, we have identified five key priorities for the Mississauga Halton LHIN. By collectively focusing our attention and energies on these priorities, we can achieve a healthier tomorrow! So let's get going!

3.0 The Provincial Context

Working With the Province to Build Healthier Communities

Local Health Integration Networks (LHINs) were established in 2005 to manage the planning, integration, performance and funding of the health care system in Ontario. As crown agencies that work in partnership with the Ministry of Health and Long-Term Care, LHINs provide leadership and accountability for the health care system at the local level, ensuring that health care needs are being identified, coordinated and addressed in a truly integrated system. With rising costs, limited resources and increased pressures, our current provincial environment requires that we get better value for money from all parts of the health care system if we want to maintain access to services and continue to improve the quality of care. The time is now for us to do things differently.

Provincial Health Priorities

In January 2012, the province unveiled Ontario's Action Plan for Health Care[iii]. The goal of the Action Plan is to create an "obsessively patient-centred" health care system by ensuring care is based on evidence, delivered in the right setting and coordinated so that consumers move from one provider to another seamlessly.

The provincial Action Plan identifies three focus areas:

- **Keeping Ontario Healthy** – supporting healthy habits and lifestyle changes, and continuing to improve management of chronic conditions
- **Faster Access and a Stronger Link to Family Health Care** – improving access to family health care resources and introducing quality measures
- **Right care, Right time, Right place** – supporting people to get the care that they need, when and where they need it

LHIN System Imperatives

To support the high-level priorities of the Minister's Action Plan, Ontario's LHINs have collectively identified several system imperatives to help guide decisions LHINs make at the local level:

- **Enhancing Access to Family Health Care** – timely access to a primary care provider and appropriate use of hospital resources

- **Enhancing Coordination and Transitions of Care for Targeted Populations** – support for those most in need to get the right care when and where they need it
- **Implementing Evidence-Based Practice to Drive Quality** – evidence-based decision making to support coordinated responses to high-priority quality issues in the system
- **Holding the Gains** – ensure that the many advances LHINs have made in improving wait times, value for money, transparency and accountability continue to move forward

Integrated Health Service Plans

Since 2005, LHINs have been accountable to their local communities to plan and integrate the health care system, in partnership with the Ministry of Health and Long-Term Care. Close alignment with the provincial strategy and priorities is essential to support transformation of the health care system in Ontario.

The province's 14 LHINs are committed to supporting the provincial goals in the Minister's Action Plan while at the same time, meet the unique needs of their respective local communities and regions. The Mississauga Halton LHIN IHSP identifies five key priorities that balance the input of our provincial leaders, health care partners and other key stakeholders – including our community at large. Working collectively on these priorities, we can make a difference.

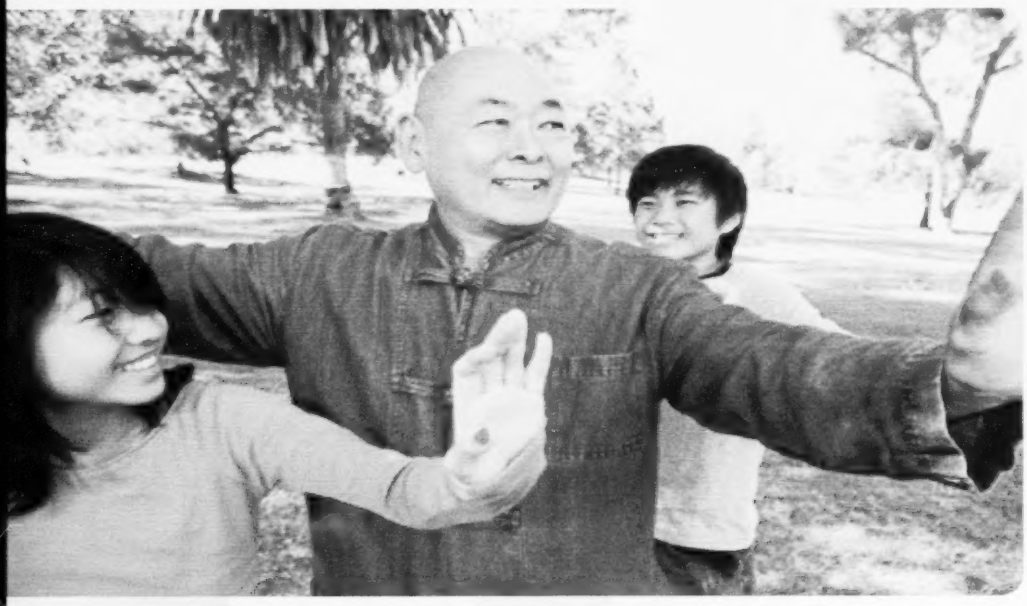
Enhancing Access to Family Health Care

Enhancing Coordination & Transitions of Care for Targeted Populations

System Imperatives

Implementing Evidence-Based Practice to Drive Quality

Holding the Gains



4.0

Mississauga Halton LHIN's Vision For The Local Health Care System

Originally established in the fall of 2006, the Mississauga Halton LHIN developed its own local vision statement to address the health care needs of our communities:

> A seamless health system for our communities – promoting optimal health and delivering high quality care when and where needed.

Reconfirmation of this vision statement by the Mississauga Halton LHIN Board of Directors is a testimony to the enduring hopes of our local community and health care providers to build a high quality, seamless health system that meets our needs, now and in the future.

For the LHIN to achieve its vision, a strategy must be created. The Mississauga Halton LHIN's mission is to lead health system integration for our communities. The work that we do is guided by **our values.**

Our Values

Accountability
Integrity
Respect
Innovation
A Holistic Approach
Partnership

Staying true to these values allows the LHIN to focus on the person and look at health from a variety of angles including: promotion, prevention, mental and physical wellness, acute care, rehabilitation, long-term care, bereavement support and caregiver respite.

Translating the Vision into Strategy

In line with our vision, our new three year plan focuses on the consumer – from a holistic approach. We want to be innovative in our approach and hold each other accountable to continuously drive quality forward. The backbone of our strategy focuses on five key priority areas:

- Accessible and Sustainable Health Care
- Family Health Care When You Need It
- Enhanced Community Capacity
- Optimal Health – Mental and Physical
- High Quality Person-Centred Care

The IHSP is a shared road map. It will help all of us understand our health care goals and the steps we must take together to build the health care system that meets our needs now and in the future. The strategic priorities identified are not mutually exclusive. However, we have tried to articulate priorities that are meaningful and resonate with everyone in the LHIN – so that we can work in collaboration to achieve our local vision.

Translating the Strategy into Reality

What does realization of this strategy look like for the people of the Mississauga Halton LHIN?

Success will allow us to see:

- A decrease in wait times to get required health services
- A reduction in hospital admissions because people will be able to get the care they need through their family health care provider or other community resources
- Adequate supports in the community to keep people safely in their homes

Success will mean:

- An equitable, high quality system, where regardless of income, age, education, sexual orientation, race and language, every person in the Mississauga Halton LHIN will have timely access to the health care options they require – those with the most serious and complex conditions will receive the extra support they need
- Services will be organized and delivered in a way that achieves the best health outcomes while being efficient
- We will be transparent and inclusive in our design and implementation processes

For each priority area of focus, specific goals with clear measures of success have been identified so we can see how we are doing and keep moving on the right path forward. Following **our principles**, we will engage the community along our journey to build innovative partnerships with health care partners, stakeholders outside of health care, as well as consumers and their families.

Our Principles

Community Engagement
Cooperation
Coordination
Equity
Accountability
Transparency
Sustainability

Success is dependent on all of us working together. Ready to start?

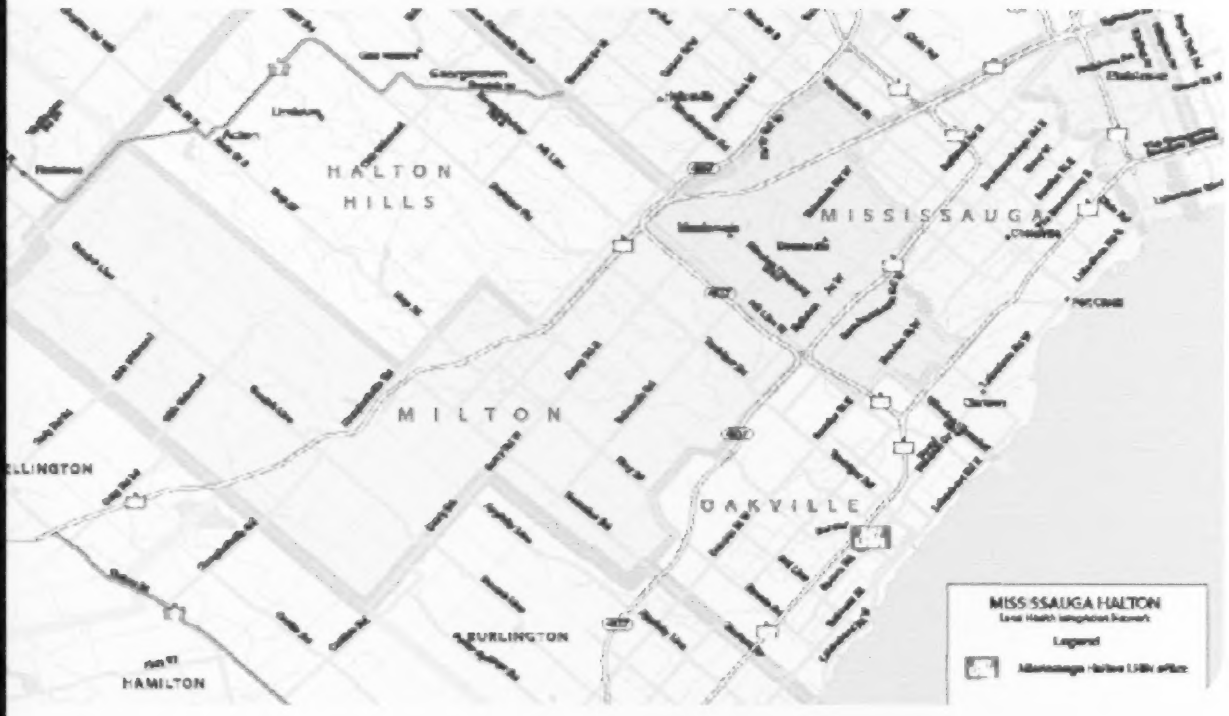
5.0

Mississauga Halton LHIN – Our Local Health System Today

Where We Live

The Mississauga Halton LHIN, home to 1,179,800 people in 2010, is one of the fastest growing and most diverse LHIN areas in the province. Covering approximately 1,059 square kilometres, the Mississauga Halton LHIN includes the regions of Halton Hills, Milton, Oakville, Mississauga (excluding Malton) and South Etobicoke (part of the City of Toronto).

During the period of 2006 to 2011, the Mississauga Halton population increased by 12 percent, the greatest rate of population growth of all LHINs. The greatest percentage



of total population growth occurred in the Town of Milton, which is recognized as the fastest growing community in Canada.

A key point for us to note in our health system planning is while our population as a whole is growing, over the next 20 years, the number of people over 65 years in our LHIN will increase at a rate that is the second greatest in the province of Ontario.

A Culturally Diverse Community

The Mississauga Halton LHIN population is one of the most culturally and linguistically diverse regions in the province of Ontario. Over one-third of our residents belong to visible minorities and 40 percent of our residents indicate that their mother tongue is a language other than English or French. Mississauga Halton is home to 35,730 Francophones, with the largest Francophone community located in the City of Mississauga. Compared to other LHIN areas, Mississauga Halton has one of the smallest numbers of Aboriginal residents with approximately 4,300 people who self-identify themselves as Aboriginal and approximately 10,000 people who report Aboriginal ancestry/origin.

The Health of Our Citizens

The residents of the Mississauga Halton LHIN are relatively healthier and have a greater life expectancy when compared to people living in other areas of the province. Health is impacted by many things including income, employment and education. While the proportion of residents in Mississauga Halton living in low income is better than the provincial average, Southeast Mississauga and South Etobicoke residents both have higher than provincial average rates of living in low income. The unemployment rate for youth in the LHIN is slightly higher than the provincial average, and the unemployment rate for adults in Southeast Mississauga is also higher than the provincial average.

MH LHIN Fast Facts

- Although the Mississauga Halton LHIN is the province's second smallest LHIN in size, it had the highest growth rate in population (12%) from 2006 to 2011, and includes the fastest growing community in Canada – The Town of Milton.
- The number of people aged 75 years and older will increase 143.4% by the year 2030.
- The top ranked non-official language spoken by MH LHIN residents in 2011 was Urdu. The predominant visible minorities are South Asian, Chinese, Black and Filipino.
- 7.3% of Southeast Mississauga and 15.6% South Etobicoke residents live in low income.
- The unemployment rate in Southeast Mississauga is higher than the provincial average.
- The youth (15-24) unemployment rate for MH LHIN is slightly higher than the provincial average.
- Six of all 10 deaths in our community are caused by chronic conditions such as heart disease, high blood pressure, diabetes and asthma.
- Over the past four years, Emergency Department visits in MH LHIN hospitals have seen a 13.4% growth increase compared to 6.4% for Ontario.

Approximately one out of three of our residents are living with chronic health conditions such as heart disease, high blood pressure, diabetes and asthma and the rates for diabetes and high blood pressure are increasing in our communities. Chronic conditions currently account for six out of 10 deaths in our community and one-quarter of all acute hospital days. As our residents age, it is more likely that they will be living with two or more chronic conditions. Rates for chronic conditions such as diabetes, heart disease and hypertension are higher in the immigrant population than Canadian-born population.

Use of Health Care Resources

Mississauga Halton LHIN is served by two public hospital corporations (which includes six sites), 28 long-term care homes[iv] (with approximately 4,100 long-stay beds), 34 community support service agencies[v], 11 mental health and addiction service providers and one Community Care Access Centre[vi] (CCAC).

Our Emergency Departments continue to experience a rise in their use, increasing the pressure to deliver timely service. We are also seeing a rise in the number of people with mental health and/or substance abuse issues accessing hospital Emergency Departments.

The demand for hospital acute care services continues to rise within the LHIN, as the number of people accessing hospital-based care rose by four percent between 2006 and 2011.

Making a Difference in the Mississauga Halton LHIN

Mississauga Halton LHIN health service providers have worked hard to significantly reduce the number of people waiting for an Alternate Level of Care (ALC)[vii] while in hospital. These individuals, who are waiting for more suitable resources to become available, significantly contribute to increases in wait times for people needing to access acute care services. Over the past four years, we have seen a significant reduction (45 percent) in the total number of hospital-based ALC consumers, due in large part to innovative strategies implemented by the Mississauga Halton LHIN such as the Home First philosophy[viii]. As well, concerted efforts have been made to increase community-based services and home care services to support people with higher care needs in their own home. Although improvements have been made, we continue to focus our efforts to ensure we are providing the right care in the right place at the right time.

With our increased focus on providing care in the community, programs such as "Stay at Home"[ix] and "Wait at Home"[x] have been enhanced over the past four years through our CCAC to assist older people (particularly those higher need seniors, 75 years and older) to remain living in their homes and delay or even prevent the need for long-term care placement. The LHIN has also supported community support service agencies to focus increased attention on seniors with higher levels of care needs through enhancements to adult day services, respite services and supports for daily living (SDL).

Through the provision of enhanced services in the community, we have also successfully been able to provide additional programs and services such as the "Restore Program"[xi] and Behavioural Supports Ontario (BSO)[xii]. Through these and other initiatives, we have seen a decrease in the number of people on the wait list for placement into a long-term care home, as well as an improvement in the use of long-term care placement for those who really need the services.

The successes to date have been achieved through the collaboration of our health service providers and partners thinking innovatively towards a common goal. These are all examples of how service providers in the Mississauga Halton LHIN are working together to ensure that people in our community receive the care they need, when they need it. We are on the right path, but there is much more to do.

6.0

Priorities for the Local Health Care System
& How We Will Measure Success

Mississauga Halton LHIN Priorities

Partnering for a healthier tomorrow is the cornerstone of our IHSP. The five key local priority areas all focus on the consumer, from a holistic perspective. As depicted in the graphic below, the priorities are not mutually exclusive, but do overlap in some way. The key to successful achievement of these priorities will be dependent on staying focused on our goals, working in partnership to develop innovative, effective action plans to support our strategies, and diligently monitoring our progress.

Family Health Care When You Need It
Accessible & Sustainable Health Care
Optimal Health – Mental & Physical
Partnering for a Healthier Tomorrow
High Quality Person-Centred Care
Enhanced Community Capacity

Accessible & Sustainable Health Care

While progress has been made, improving access to health care continues to be a significant focus. Being able to receive the care that you need, when you need it, is a critical aspect of quality health care to the people within our communities. The entire health care team across the continuum of care, including the community, must link together as an integrated system to reduce unnecessary hospital admissions. Integration and the development of regional programs are key elements of our work. We will work in partnership to continually look for innovative ways to improve consumer flow and access to safe, high quality care in our current fiscal environment.

Our health care system can be confusing, overwhelming and complicated to navigate for both consumers and clinicians. People find the journey through the system more "daunting than the disease itself" (Kasperski, 2011). One of the keys to coordination is effective communication. Ensuring information is shared effectively is particularly critical when people are moving between settings or clinicians.

Ensuring health care providers, consumers and their families are fully aware of the array of services available and understand how they can access these services is equally critical. In a well coordinated health care system, people will be able to access the care they need, avoid redundant tests or procedures and readmissions to hospital are more likely to be avoided.

Building a health care system that is sustainable for future generations is important to all of us. The system needs to provide value not only economically, but also value related to health outcomes. To support this approach, funding should follow the needs of the consumer. In support of health system funding reform, regional capacity plans enable us to move towards standardization of care to minimize practice variation and strengthen the link between the delivery of quality care and fiscal sustainability. Focusing on how to best serve those who are frequent users of health care resources (high users) will also support sustainability of the health care system. Our communities are growing and our health human resources are challenged to keep up with increasing demands. It is therefore imperative that we explore opportunities to partner, leverage existing resources, and look at creative ways to avoid duplication and support clinicians to practice to their maximum scope.

Lily's recovery blossoms with a customized care plan

At 91 years old, Lily was very independent and spent much of her time tending to the large vegetable plot in her backyard. Unfortunately, Lily fell while watering her garden and broke her hip. Following surgery, Lily required a great deal of assistance and moved in with her 65-year-old daughter, Ava, while waiting for placement in a long-term care facility. Ava soon became overwhelmed with the day-to-day requirements of her mother's care needs and was on the verge of burning out.

Case manager Grace Martin, from the Mississauga Halton Community Care Access Centre (CCAC), began working with Lily and Ava, bringing a considerable amount of clinical expertise, a fresh perspective and a positive outlook to the deteriorating situation.

As Lily's personal health advisor and care coordinator, Grace worked with Ava to identify personalized solutions to help manage Lily's intensive care needs. Grace recognized who Lily was before the health crisis and not just the symptoms that required treatment. She worked with Lily's personal support workers (PSWs) on strategies to engage her, such as looking at family photos and talking about her grandchildren and garden. Grace continued providing guidance and expertise to refine Lily's care plan. A new exercise program helped Lily improve her strength and mobility.

When a place in long-term care became available to Lily, Ava felt satisfied that she had provided the best care possible for her mother with the personalized planning and guidance from Grace.

Our Goals for Accessible and Sustainable Health Care

Improve access to services to improve consumer flow, quality and safety

Strategies to move us forward:

- Establish new ways of working in and with Emergency Departments to reduce wait times
- Develop innovative and collaborative approaches to reduce unnecessary hospital stays and avoidable hospital admissions and readmissions
- Leverage evidence-based practices to reduce wait times for priority surgical services (i.e. hips, knees, cataracts, cancer, cardiac bypass)
- Integrate services to support regional programs and system effectiveness

Support consumers, families and health care professionals to navigate the health care system

Strategies to move us forward:

- Begin planning for transitions early and include all care providers, including informal caregivers and family health care
- Enhance provider awareness and knowledge of the health care system and available resources
- Provide service navigation to consumers and their caregivers during transitions within the health care system

Improve the sustainability of the health care system

Strategies to move us forward:

- Develop regional, integrated capacity plans to support health system funding reform (i.e. integrated orthopaedic capacity plan) and implement funding for selected health programs based on the needs of consumers (quality based procedures)
- Focus on seniors and those individuals who utilize a significant proportion of our health care resources and how to meet their needs with greater efficiency
- Work in partnership with health care providers and partners to explore maximizing scope of practice, utilizing services in different ways to improve access
- Manage growth in capacity required as a result of population increases and aging

How We Will Measure Success

A number of high level quantitative and qualitative indicators will be monitored over the life of the IHSP to measure improvements in accessibility and sustainability within our local health system. These indicators demonstrate the ability of the system to respond to local and provincial health priorities. It is critical when measuring success that we include qualitative information that captures the experience of the person receiving health care services. This will tell us how people believe the system is working and if we have made a difference. Specific indicators for each goal (and the strategies within) will be included in the Mississauga Halton LHIN Annual Business Plan for each year of the IHSP.

Measures of an accessible and sustainable health care system will include:

- Reduction or maintenance of low wait times for Emergency Department (ED), surgical and diagnostic services
- Fewer repeat ED visits for individuals with mental health concerns and/or addictions
- Increased number of individuals and caregivers reporting an understanding of service options and how to access services
- Reduction in the number of hospital readmissions for people who were recently discharged following a hospital stay
- Increased number of regional, integrated programs that meet the service needs for individuals with complex care needs

Family Health Care When You Need It

Access to family health care continues to be a local priority. As the first point of access for people seeking health care within the LHIN, a strong family health care system is critical for better outcomes, improved quality and sustainability of the system as a whole.

Family health care is centred on the consumer. It includes preventative health care, screening and early detection of illness, coordination with hospitals following an admission (including appropriate follow up) and facilitation of smooth transitions between clinicians and across settings and services. If people can access family health care when needed, they will stay healthier and reduce the need to be admitted to hospital.

In our LHIN, currently 18 percent of family physicians can provide same or next day appointments with almost half having arrangements for after-hours care. While most of our residents do have access to family health care, if it is not provided when they need it, many people resort to using the Emergency Department as a default.

Through Health Care Connect[xiii], efforts have been made to link more people with family physicians. There has also been a shift in the model of care from solo to group practice, including the development of interdisciplinary family health care teams, which supports a person-centred approach to care delivery.

An integrated approach to care has been identified as critical to the delivery of quality health care. Essential to the development of this integrated approach is a full awareness of the services and resources available in the system, as well as enhanced linkages between family health care providers and their partners in the broader health care system, in particular, specialists to support them in their clinical practice.

Electronic health records are also an essential tool to support coordination of care, particularly for people with complex health care needs who need to see a number of professionals across different sites. eHealth initiatives are underway to standardize referral processes, efficiently transition consumers through pathways and connect electronic medical reports and information to the electronic health record. With continued advances in technology, including telemedicine, the ability to be nimble and flexible to leverage technological advances supports family health care providers to better connect and to have the required information at their fingertips when they need it to provide safe, high quality care.

> "I have had my family doctor for almost my entire life. When I call for an appointment, I'm usually offered something that is three days away, at a time that is not convenient. If I take the appointment time and I do go to see him, I have to wait over an hour in the waiting room. Because of these issues, now when I have to get family health care that I feel is not complicated, I usually go to a walk-in clinic. It's not ideal, but at least I can get the care that I need when I need it. I do wish however that my family physician would make changes to his practice so I could see him on a regular basis when I need to."

Our Goals for Family Health Care When You Need It

Improve access to family health care

Strategies to move us forward:

- Leverage Health Care Connect to support consumers who want or need a family health care provider to get one, particularly for those people who are admitted to hospital or frequently visit the Emergency Department
- Improve access to same-day or next-day appointments and after-hours care including home visits and mobile clinics
- Increase access to multi-disciplinary health care teams

Increase linkages between family health care and other health care providers to improve communication, coordination and integration across the continuum of care

Strategies to move us forward:

- Improve coordination of care between providers (particularly for complex consumers who are at high risk for readmission or high users of the system) through the development of Health Links[xiv]
- Increase capacity of family health care providers to manage an increased complexity of consumer care through the provision of consultations with specialists
- Improve communication with family health care providers through consistent and timely sharing of consumer information
- Leverage technology (i.e. electronic medical records, portals, Ontario Telemedicine Network) to promote sharing of information between providers

How We Will Measure Success

Success in providing "family health care when you need it" will be demonstrated by improved ways to access family health care and improved communication between family health care providers and others. Specific activities within the LHIN's Annual Business Plan for each year of the IHSP will be measured to monitor if the identified goals and strategies support achievement of this priority.

The ability to receive family health care when you need it will be measured by:

- Increased number of linkages with a primary care provider for people (currently without a primary care provider) who want or need this service
- Increased number of family health care providers who provide alternate and/or integrated methods of access for their patients
- Increased number of people in priority service groups receiving primary care appointments within seven days post hospital discharge
- Increased number of health care professionals accessing and sharing patient information through an electronic medical record, information portals or other electronic technologies
- Increased ability for family health care providers to monitor the care progress of high needs individuals on a "real-time" basis

Enhanced Community Capacity

There has been much discussion on providing the right care in the right place at the right time. Many people prefer to receive care in their home or community instead of in hospitals and long-term care homes. However, to support this model of care, the appropriate community supports need to be available.

As we shift our approach to health care delivery, the capacity within the community needs to be built both in terms of managing the volume of services available and ensuring providers and caregivers have the skills and supports necessary to best meet the needs of the increasingly complex consumer.

Two-thirds of Canadians requiring service report difficulties accessing care in the evening, on weekends and holidays (Change Foundation, 2011). Consumers and caregivers in the Mississauga Halton LHIN told us that care needs to be provided in a timely and convenient manner – minimizing the need to go to multiple locations for services. When seeing multiple providers across the LHIN, access to transportation or having the care come to the consumer (through mobile teams or telemedicine) offers viable options to those who struggle to access care in our current system.

By serving people appropriately in the community, the entire health care system will benefit. Receiving care in the home will improve the consumer's experience. The risks to consumers will be reduced. More support with daily tasks will result in fewer hospitalizations and placements. Hospital and long-term care beds will be available for those who most need them. Our healthier tomorrow is taking shape.

Meals on Wheels provides a nutritious meal, but also the daily contact with volunteers helps brighten up clients' days. A kind word and a smile can work wonders.

James Jr. came to the Links2Care office a few months ago to see if there were any services that would benefit his father. Because of his shift work, James Jr. could not always be there to help. James Sr., a widow, had his driver's licence taken away due to a heart condition, was always short of breath, had started to fall frequently and was not eating properly. He was not the most social of people either, especially since his wife passed away six months ago. He wanted to stay in his house, but it was becoming a safety issue with the risk of isolation.

Links2Care arranged Meals on Wheels for James Sr., who now looks forward to his meal delivery, is not falling as much and has even gained a bit of weight. James Jr. is more at ease knowing his dad has daily contact, a nutritious meal and most importantly, can stay at home for the time being.

Our Goals for Enhanced Community Capacity

Enable people to stay in their homes longer

Strategies to move us forward:

- Manage the volume of services in the community to reduce wait times and meet demand for vulnerable populations such as seniors, palliative consumers and those with mental health concerns and addictions
- Provide support for medication management and instrumental activities of daily living such as meals and homemaking to avoid institutionalization
- Support caregivers by providing adequate training, respite and coordination of service
- Ensure appropriate staffing through enhanced training to attract skilled staff to serve consumers with complex needs in the community

Provide integrated services that bring care closer to home

Strategies to move us forward:

- Create community centres for health where people can access integrated services that address more than one need in a single stop
- Address transportation challenges or bring programming to convenient locations (home or community-based) to meet the needs of specific target groups
- Maximize use of technology to bring care closer to home

How We Will Measure Success

Successful enhancement of the capacity of services in the community will mean we are better able to meet the needs of people and allow them to remain in their own homes in the community as long as possible. We will measure the services available, number of people receiving service and also changes in how services are delivered. We will also look to hear from people receiving these services and their caregivers or family members to determine how we have done in meeting their needs.

Measures that will indicate our ability to enhance community capacity are:

- Increased number of caregivers receiving supports such as respite, and training for safe care provision that allow them to safely support their family member at home
- Increased number of individuals in priority populations receiving case management and service coordination
- Increased number of people receiving service through local integrated service centres
- Increased number of service staff that receive enhanced training to understand and assess complex care needs

Optimal Health – Mental & Physical

Chronic disease is the leading cause of death in Ontario (Ontario Agency for Health Protection and Promotion and Cancer Care Ontario, 2012). Over 50 percent of Ontarians aged 45-64 are living with at least one chronic condition (Health Council of Canada, 2012). Chronic disease in children and adolescents is on the rise. We are raising the first generation of children whose life expectancy is expected to be lower than their parents (Olshansky, et al, 2005). These largely preventable diseases diminish our quality of life, economy and communities (Ontario Agency for Health Protection and Promotion and Cancer Care Ontario, 2012). If we are truly looking to build a high quality, sustainable health care system, we must start focusing our attention and efforts toward chronic disease prevention and optimizing both mental and physical health.

The current health care system was designed to deal with disease – treating people once a health problem has occurred rather than focusing on an approach that might prevent problems or lessen the effects. While we have successfully been able to help people grow to an older age, there is opportunity to assist them in doing so more gracefully. Chronic conditions such as heart disease, high blood pressure, diabetes and asthma account for six out of 10 deaths in the Mississauga Halton LHIN, and one-quarter of all acute hospital days. The prevalence of mental health concerns and addictions is also on the rise, in adults and in our youth.

The provincial action plan states "Helping people stay healthy must be our primary goal and it requires partnership" (Ministry of Health, 2012). Keeping people healthy is a responsibility that must be shared across the various levels and ministries of government to make a difference. We also need to collaborate with non-government partners in sectors beyond the realm of health as the factors that influence our health branch out into many areas. Healthy communities are built through partnerships, and leveraging the expertise of people with lived experience offers a sustainable, effective mechanism to optimize health.

To successfully increase healthy habits and prevention of disease, people's health concerns need to be addressed in consideration of their living and working conditions, as well as social supports. By focusing attention on health promotion and prevention of disease, the health of our communities will improve. People will enjoy a better quality of life and live longer. People won't need health care services as often or as intensively. By investing in these areas, the rising costs associated with chronic disease will decrease, supporting our plans for a healthier tomorrow.

STRIDE Success Story

I was diagnosed with major depression and anxiety in 2004. I had been struggling, working as a single mom with no support. Although I did not want to stop working, I was not ready to continue participating in the world of work and all its stresses. That's where STRIDE made a difference. I began working with STRIDE through the Worksite Training program and it was an ideal compromise as I was "working" but in a safe environment. Through STRIDE, I met other people who had experienced similar situations, which helped me better accept my diagnosis. I learned that I could maintain structure, which may seem trivial, but for someone who has an illness which inhibits motivation and ambition, this is a success.

After three years, I decided to take a chance and enter the workforce. The first job I had was at a vet clinic, and I stayed there for a year and a half before moving on to other kinds of employment. However, I wanted more. My daughter was getting older and more independent and I was reaching the ripe old age of 40. After participating in STRIDE, I recognized that I enjoyed helping people, so I took another leap of faith, and applied to the School of Social Work at McMaster University for their post-degree program. In June 2010, I was accepted.

Currently, I am doing a placement at the Catholic Children's Aid Society in Hamilton. It is difficult and emotional work. I supervise family visits which can be stressful but at the same time, enjoyable. It makes me realize I was lucky to have supports like STRIDE in place for my daughter and I. I struggled with the mental illness label but STRIDE gave me a sense of normalcy.

Our Goals for Optimal Health – Mental and Physical

Increase healthy habits and prevention of disease

Strategies to move us forward:

- Leverage existing resources for chronic disease and develop an integrated model and approach to chronic disease prevention and management that supports individuals through their lifespan
- Partner with public health to support approaches to healthy lifestyles and disease prevention
- Promote healthy workplace policies, leading by example through the work of our health service providers

Build partnerships for healthy communities

Strategies to move us forward:

- Develop partnerships across various sectors such as municipalities, public health, education and social services to collaborate on issues relating to or impacting on health such as the social determinants of health
- Leverage the expertise of people with lived experience and expand/develop peer support initiatives and networks

How We Will Measure Success

The measurement of a health care system that supports "optimal mental and physical health" will be in our ability to influence optimal health and support prevention and promotional activities. For those people who currently are living with complex, chronic health conditions we will measure the ability to have their needs met in a coordinated and integrated fashion.

Measures of success to support optimal health include:

- Increased number of people with chronic conditions accessing regional, integrated service delivery and self-management supports
- Increased number of initiatives that include people with lived experience and include peer support opportunities
- Increased number of partnerships with social services, education and public health that result in opportunities to promote healthy lifestyle and disease prevention

High Quality, Person-Centred Care

The Excellent Care for All Act[xv] identifies the need to improve the quality and value of the consumer and caregiver experience. There is an increased demand for measurable performance and quality measures as shown by the requirement for hospitals to establish quality committees and prepare annual quality improvement plans. This culture of quality needs to be supported and fostered across the local continuum of care ensuring that all health service providers have the capability and capacity required for this quality focus.

Only 15 percent of physicians routinely gather and review data on their clients' satisfaction and experience with care. We need to better understand the consumer experience to be able to respond to the needs of our customers. In listening to the experiences of consumers relating to our health care services, clear ideas emerged about where opportunities lie. People value having adequate time during appointments, being able to access health care providers by phone between appointments, receiving active follow up and getting help coordinating their care. People want to be treated with respect, to have their preferences about their care options taken seriously and have their feelings acknowledged. Like any good business, the voice of the consumer is paramount. Health care is no different. Consumers need to be involved in the planning and designing of health care services as a means to improve quality of care and strengthen accountability in the system.

It is important for all of us to recognize and understand that people may have different expectations on how and when to connect with health care services. People are also not able to access services in an equitable manner, sometimes as a result of stigma or marginalization. By applying a health equity lens and including community representatives in the planning and implementation of health care services, we will better understand how different communities typically access services and ensure that we are developing strategies to meet the needs of our residents in an appropriate, equitable and respectful manner.

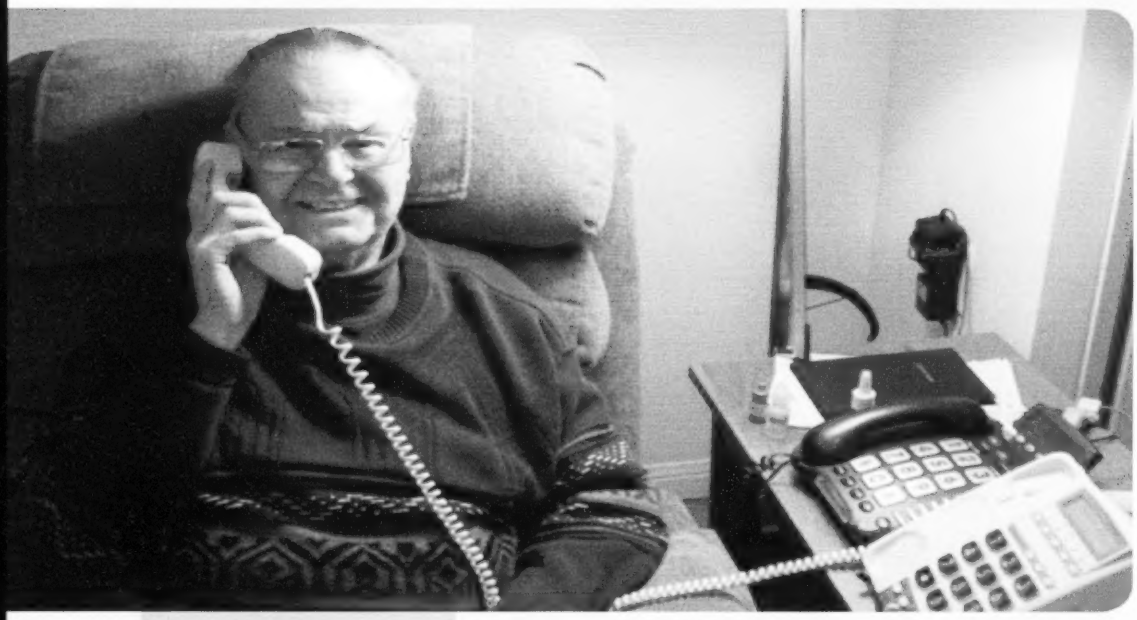
Enhancing the consumer experience is not a choice, but a necessity. A focus on positive person experiences is targeted, cost-effective health care that leads to better care outcomes and improved quality of life.

"I have been living with a severe hearing loss for years, and for years, I was not able to understand people – especially over the phone. It was a very frustrating time for both family and friends. It affected many of my relationships.

The Hearing Care Counsellor and the Audiologist at the Canadian Hearing Society helped change that. I don't drive anymore, so getting around can be a challenge. The counsellor came to my home and demonstrated different devices until we found the right fit for me. They were able to help me get a Voice Carry Over (VCO) phone and the counsellor taught me how to use it. I now read what others say to me and no longer struggle on the phone.

The support I've received from the Canadian Hearing Society has been wonderful. The staff really understood what I was going through and were there for me every step of the way. I call family and friends more often now and can finally understand what they are saying to me. Struggling with a hearing loss can be lonely, but you don't have to go through it alone."

Leon Corkum -
World War Two veteran



Our Goals for High Quality, Person-Centred Care

Continue to support and foster a quality culture across the continuum of care

Strategies to move us forward:

- Implement The Excellent Care for All Act at a local level to embed a culture of quality within all LHIN health service providers
- Develop mechanisms for tracking quality of care, safety and system effectiveness as it pertains to desired outcomes
- Implement consistent care pathways and standardized care plans (i.e. discharge plans)
- Use scientific evidence to support effective utilization of health care dollars

Value people's experiences to support system improvement

Strategies to move us forward:

- Identify person experience metrics and use to guide service improvement and development
- Ensure services are flexible to meet consumer and caregiver needs
- Include people with lived experience as active members of planning and quality improvement teams
- Develop a LHIN-wide customer service focused approach

Apply a health equity lens for the delivery of health care services

Strategies to move us forward:

- Raise awareness and decrease stigma to minimize marginalization
- Focus on the most vulnerable populations and develop awareness and understanding of health equity issues to support those in need
- Support the provision of services which are linguistically and culturally competent
- Work in collaboration with the French Language Service Entity (Reflet Salvéo) and Aboriginal leaders to leverage existing capacities and explore new opportunities to meet the respective needs of the Francophone and Aboriginal communities

How We Will Measure Success

The measurement of how well we create high quality person-centred care must include the input of those people receiving health care services. It is really the person who receives the care that can best provide information to measure service effectiveness. As such, we will use indicators that identify how well we do at ensuring that health care providers understand how to implement both high quality and client-centred care services and collect qualitative information on patient experiences.

Measures of high quality person-centred care include:

- Increased number of people with lived experience directly involved in the planning and quality improvement of health care services
- Increased number of health service providers that receive training on quality improvement methodologies to implement quality improvement strategies
- Increased number of health service providers that receive health equity training and provide services to meet the unique characteristics of our vulnerable populations
- Increased number of people who are able to receive health care services in a fashion that they believe appreciates their unique needs without stigma

7.0 Conclusion

Much has been accomplished over the past six years by the Mississauga Halton LHIN to meet the health care needs of the community. Building on successes, new identified needs and the changing landscape of our region, as articulated in this IHSP, there is more to be done and we have now established our plan to go forward.

Success of the IHSP is supported by a number of key enablers:

- Building awareness
- Health system funding reform
- Community engagement
- Information management & technological advances
- Collaborative governance
- Communication
- Accountability management
- Partnerships

Leveraging these enablers to support achievement of the goals identified under each of the five local health system priorities will be essential. Our plan is ambitious, yet realizable. The strategies that have been identified to achieve our goals will be further articulated every year in our Annual Business Plan. The measures of success will be reviewed regularly to guide and refine our plans over the next three years and keep us on course.

We need to be flexible and nimble to adjust to the changing environment that we live in. We need to be able to look to the evidence, listen to our people and respond in the appropriate manner. This IHSP was built in the spirit of partnership – with providers, consumers, caregivers, cross-sector partners and the community at large. By developing a plan that is not only evidence-based, but built on the foundation of the voices of the people that it serves, all partners now have a stake in achievement of its success.

And success is important… because we all want a healthier tomorrow.

8.0 References

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An Appendices document is available on the Mississauga Halton LHIN website, with a more detailed review of the environmental scan, community engagement process and stakeholders, priority development and comprehensive reference literature review listing.

9.0

Glossary of Terms
(Endnotes i-ix)

[i]**LHIN** stands for Local Health Integration Network. LHINs are community-based organizations that plan, coordinate, integrate and fund health care services at the local level.

[ii]**Family health care** refers to family doctors, nurse practitioners and other primary health care providers.

[iii]**Ontario's Action Plan for Health Care** was released in February 2012. It aims to build a quality health care system that is more responsive to patients and delivers better value for taxpayers.

[iv]**Long-term care homes** are care for those who can no longer live independently in a residential setting.

[v]**Community support service agencies** provide a variety of services including adult day programs, in home nursing care or assistance with daily tasks such as bathing and dressing.

[vi]**Community Care Access Centres** help people stay at home by providing care in people's homes or coordinating community services to support them.

[vii]**Alternate Level of Care** refers to patients who are occupying a hospital bed but no longer require the intensity of services provided in that care setting and are waiting to be transferred or discharged to another care setting when it is available.

[viii]**A Home First** philosophy aims to have patients who are admitted to hospital return home on discharge, prior to assessment for and admission to a long-term care home or other appropriate care setting.

[ix]**Stay at Home** refers to a program for seniors at high risk for being placed in a long-term care home, who choose to remain in the community with enhanced supports, rather than enter a long-term care home.

Glossary of Terms
(Endnotes x-xv)

[x]**Wait at Home** is a program that enables people to return home with health care supports for a 60-day period while waiting for placement in a long-term care home.

[xi]**Restore Program** is a short term restorative and activation program for elderly post-acute hospital patients who need supports to regain the ability to perform independent activities of daily living to safely return to their home in the community and prevent premature long-term care placement.

[xii]**Behavioural Supports Ontario** enhances local services for seniors with complex and responsive behaviours to improve care wherever they live – at home or in the community.

[xiii]**Health Care Connect** is a program that helps people without a family health care provider to find one.

[xiv]**Health Links** will encourage greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports. With improved coordination and information sharing, patients will receive faster care, will spend less time waiting for services and will be supported by a team of health care providers at all levels of the health care system.

[xv]**The Excellent Care for All Act** became law in 2010. It defines new standards to ensure Ontarians receive health care of the highest possible quality and value.

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Mississauga Halton LHIN expresses its sincere appreciation to our community and staff who allowed us to use their images and stories in this report.

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